ADULT CARDIAC ARREST

FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting

BLS INTERVENTIONS

1. Assess patient, maintain appropriate airway, and begin CPR according to current AHA Guidelines.
   a. Ventilation rate shall NOT exceed 12/min. Ventilatory volumes shall be the minimum necessary to cause chest rise.
   b. Compression rate shall be 100/minute utilize 30:2 compression-to-ventilation ratio for synchronous CPR prior to placement of advanced airway.
2. If available, place AED and follow Protocol Reference #6301 AED. CPR is **not** to be interrupted except briefly for rhythm assessment.

ALS INTERVENTIONS

1 Initiate CPR for 2 minutes if no CPR was performed prior to arrival and down time is greater than 5 minutes.
2. Determine cardiac rhythm, and proceed to appropriate intervention.
3. Establish advanced airway when resources are available, with minimal interruption to CPR. After advanced airway established, compressions would then be continued at 100 per minute without pauses during ventilations.

Ventricular Fibrillation/Pulseless Ventricular Tachycardia

1. Defibrillate at 360 joules for monophasic or biphasic equivalent per manufacture. If biphasic equivalent is unknown use 200 joules.
2. Perform CPR for 2 minutes after each defibrillation.
3. Administer Epinephrine 1.0mg IV/IO during 2-minute cycle of CPR after each defibrillation.
4. Reassess rhythm, after each 2-minute cycle of CPR. If VF/VT persists, defibrillate as above.
5. After two cycles of CPR administer Lidocaine 1.5mg/kg IV/IO. May repeat at 0.75mg/kg every 5 minutes to maximum dose of 3.0mg/kg.
6. If patient remains in pulseless VF/VT after five cycles of CPR, consult base hospital.

Pulseless Electrical Activity (PEA) or Asystole

1. Assess for reversible causes and initiate treatment
2. Continue CPR with evaluation of rhythm every 2 minutes
3. Administer fluid bolus of 300ml NS IV, may repeat.
4. Administer Epinephrine 1.0mg IV/IO during 2-minute cycle of CPR after each rhythm evaluation
5. Consider administration of Atropine 1.0mg IV/IO after second 2-minute cycle of CPR. May repeat twice for a total of 3.0mg
6. Consider termination of efforts if patient remains in PEA <60, asystole (confirm in two leads), or other agonal rhythm after successful intubation and initial medications without a reversible cause identified.

Utilize the following treatment modalities while managing the cardiac arrest patient:

- If unable to establish IV/IO, Epinephrine and Atropine may be administered at double their IV dose via ET per protocol Reference #4013 Tracheal Instillation of Medications.
- Obtain blood glucose, if indicated, administer Dextrose 50% 25gms IV
- Insert NG/OG Tube to relieve gastric distension per Protocol Reference #4021 Insertion of NG/OG Tube.
- Naloxone 2.0mg IV/IO/IM for suspected opiate overdose

NOTE

1. For continued signs of inadequate tissue perfusion after successful resuscitation a Dopamine infusion of 400mg in 250ml of NS may be initiated at 5-20 mcg/kg/min IV to maintain signs of adequate tissue perfusion.
2. May initiate Lidocaine infusion of 2mg/min with documented conversion from VT/VF
3. Base hospital physician may order additional medications or interventions as indicated by patient condition.
4. Base hospital contact is <u>required</u> to terminate resuscitative measures. A copy of the EKG should be attached to the PCR for documentation purposes.

APPROVED:

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ICEMA Medical Director Date

_____ _____
Inyo & Mono Co. Health Officer Date ICEMA Executive Director Date